MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11945

CERTIFICATE OF DEATH

Reg. Dist. No. 11855

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cavetown
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cavetown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: Florence — Last: Bachtell

4. DATE OF DEATH: Month: Oct. — Day: 25, — Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 2, 1868

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Foxville, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ephraim Hauver

14. MOTHER'S MAIDEN NAME: Ellen Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: - -

INFORMANT: Mrs. Eva Kimble, Address: Cavetown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	4 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart	15 yrs
DUE TO		
(c)	Generalized Arteriosclerosis	15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/14/59 to 10/25/59 19___, that I last saw the deceased alive on 10/25/59, 19_____, and that death occurred at 1 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: G A Kohler M.D. — ADDRESS (Street, city or town, state): Smithsburg, Md. — DATE SIGNED: 10/26/59

PHYSICIAN'S NAME (Type): G. A. Kohler

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-27-59

22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR DATE: OCT 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11874

CERTIFICATE OF DEATH

Reg. Dist. No. 11856

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 834 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: A — Last: BAKER

4. DATE OF DEATH: Month: October — Day: 14 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 2 1877

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: PENN. R. ROAD Co.

11. BIRTHPLACE (State or foreign country): WAYNESBURO, PA. R.D 3 Antietam Junction

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abram L. Baker

14. MOTHER'S MAIDEN NAME: Barbara King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. John A. Baker, 834 Virginia Ave., Hag., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
332x
DUE TO
(b): Hypertensive Vascular Disease — 3 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10, 1959, to Oct 14, 1959, that I last saw the deceased alive on Oct 14, 1959, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N. Potomac St. — DATE SIGNED: 10/15/59

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/17/59

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or county) (State): Waynesboro, Franklin Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter J. Moore, Waynesboro Pa

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875 **CERTIFICATE OF DEATH** 11857

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 602 W. WASHINGTON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ANGELO — Middle N.M.N. — Last BARTON

4. DATE OF DEATH: Month OCTOBER — Day 27 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCTOBER 27, 1959

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: KENNETH EUGENE BARTON

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH RUTHERFORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MOTHER — HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

762.5

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Premature Birth at 5½ months

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-27, 19 59, to 10-27, 19 59, that I last saw the deceased alive on 10-27, 19 59, and that death occurred at 3:57 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. Waddill M.D. — ADDRESS (Street, city or town, state): 115 King ST. Hagerstown Md. — DATE SIGNED: 10-27-59

PHYSICIAN'S NAME (Type): Samuel F. Waddill — 115 King ST. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10-27-59

22c. NAME OF CEMETERY OR CREMATORY: Wash. Co. Hosp.

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Samuel J. Waddill — ADDRESS: 115 King ST. Hagerstown

24a. REC'D BY REGISTRAR DATE: NOV 3 '59

24b. REGISTRAR'S SIGNATURE: Clifton E. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2081221 XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11858

11876 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1120 Fairview Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK; Middle DE SALES; Last BECKHAM

4. DATE OF DEATH: Month October; Day 7; Year 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 23, 1874

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Administrative Officer

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Army

11. BIRTHPLACE (State or foreign country): Nokesville, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Madison Beckham

14. MOTHER'S MAIDEN NAME: Susan Ritenour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Career Off.

16. SOCIAL SECURITY NO.: 231-26-0952

17. INFORMANT: Mrs. Stanley R. Lipson
Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Perinephritic Abscess — INTERVAL BETWEEN ONSET AND DEATH: 4 days
600.0
DUE TO
(b): Pyelonephritis — yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign Prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 2, 19 59, to Oct. 7, 19 59, that I last saw the deceased alive on Oct. 7, 19 59, and that death occurred at 5 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D.
ADDRESS (Street, city or town, state): 214 N. Potomac St. Hagerstown, Md.
DATE SIGNED: 10/8/59

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/1959
22c. NAME OF CEMETERY OR CREMATORY: Manassas Cemetery
22d. LOCATION (City, town, or county): Manassas (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Chas. L. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11877

11859

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WAsh County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg R # 2
d. STREET ADDRESS: Greensburg Road
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First BARBARA — Middle JEAN — Last BELL

4. DATE OF DEATH: Month October — Day 6 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 6 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Walter Bell

14. MOTHER'S MAIDEN NAME: Betty Rayetta Stuller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Frank W. Bell Smithsburg R # 2 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congenital Heart Disease & Atresia of Lungs — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b): ——

DUE TO (c): ——

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7545

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-6 19 57 to 10-6 19 57 that I last saw the deceased alive on 10-6 19 57, and that death occurred at 5:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 135 No. Pot. St. — DATE SIGNED: 10-7-59

PHYSICIAN'S NAME (Type): Dr D.J.Boyer 135 No Potomac St

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/7/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown WAsh Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

2081574XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11873 — 11860 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate as directed in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 63 Hagerstown
d. STREET ADDRESS: 316 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle Susan — Last Bellomo

4. DATE OF DEATH: Month October — Day 27, — Year 1959

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: July 3, 1919 — 9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Franklin Co. Penna.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David W. Myers
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Shatzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 183-12-4055
17. INFORMANT — Address: Mr. David W. Myers, Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Confluent lobular pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Multiple lung abscesses
DUE TO
(c): Bronchiectasis — 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Dr. E. W. Dellinger M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): DR E W DELLINGER
DATE: 10/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-29-1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Greencastle, Franklin Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Harold W. Zimmerman — ADDRESS: Greencastle, Pa.
24a. REC'D BY REGISTRAR — DATE: OCT 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11946

Reg. Dist. No. 302 — 11861

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paramount
c. LENGTH OF STAY IN 1b: 19 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, R.F. D.
d. STREET ADDRESS: Paramount
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rae — Middle: Beatress — Last: Boone

4. DATE OF DEATH: Month: Oct. — Day: 17 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 1, 1899

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Foxville, Fred, Cty, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Ernest DeLawter

14. MOTHER'S MAIDEN NAME: Nora Gall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO: None

17. INFORMANT: John E. Boone Sr., Hagerstown, R.F.D Paramount, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis with Thrombotic Episodes — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

332 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arterial Hypertension — 10 yrs

DUE TO (c): Atrophic Left Kidney — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary-arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-2-52 19__ to 10-17 19 59 that I last saw the deceased alive on 10-17 19 59 and that death occurred at 4:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Dalton M. Welty M.D. — ADDRESS (Street, city or town, state): Hagerstown, Maryland — DATE SIGNED: 10-19-59

PHYSICIAN'S NAME (Type): DALTON M. WELTY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/19/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11947

CERTIFICATE OF DEATH

11862

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 1yr. 6 mos. 2 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport X
d STREET ADDRESS: 17 South Conococheague
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Sarah Middle M. Last Boppe

4. DATE OF DEATH: Month October Day 20 Year 1959

5. SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3 1880
9. AGE (In years last birthday) 79 yrs
IF UNDER 1 YEAR: Months 5 Days 16
IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cleaning woman
10b. KIND OF BUSINESS OR INDUSTRY: Homes
11. BIRTHPLACE (State or foreign country): Washington County
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John B. Rpe
14 MOTHER'S MAIDEN NAME: Elizabeth Cunningham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 168 24 4640
INFORMANT: Mrs. Alvey Banzhoff Address 202 S. Artizan St. Williamsport, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (b): Arteriosclerotic Heart Disease. — Years
DUE TO (c):
Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART 1(a): None.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from May 10, 19 57, to Oct. 20, 19 59 that I last saw the deceased alive on Oct. 19, 19 59 and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D.
ADDRESS (Street, city or town, state): 119 North Potomac St.
DATE SIGNED: Oct. 21, 1959

PHYSICIAN'S NAME (Type): R. A. Bell, M.D. Hagerstown, Maryland.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23 1959
22c NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf ADDRESS: Williamsport
24a. REC'D BY REGISTRAR DATE: OCT 26 59
24b REGISTRAR'S SIGNATURE: Orthus E. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11863

Reg. Dist. No. 11879

1 PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 42 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 21 N. Locust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Mae — Last: Boyd
4. DATE OF DEATH: Month: October — Day: 12 — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 25, 1903
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS: Hours: ___ Min.: ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Berkley Springs W. Va.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Ellie Johnson
14. MOTHER'S MAIDEN NAME: Emeline Waugh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edgar M. Boyd — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: ___ days
DUE TO (b): Cerebral Congestion
DUE TO (c): Infarction of Cerebellum, Old, Inferior Surface, Left. — Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
330-X
Report from autopsy not yet received.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): [illegible]
DATE SIGNED: 10/22/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-15-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR: OCT 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11880 — Reg Dist. No. 11864

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: FREDERICK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL KNOXVILLE
d. STREET ADDRESS: RT. #1 PETERSVILLE MD.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HERMAN — Middle ATLEE — Last BOYER JR.
4. DATE OF DEATH: Month OCTOBER — Day 5 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 4/9/1944
9. AGE (In years last birthday): 15 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b. KIND OF BUSINESS OR INDUSTRY: HIGH SCHOOL
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HERMAN A. BOYER SR.
14. MOTHER'S MAIDEN NAME: HELEN G. PFEIFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
INFORMANT: MR. HERMAN A. BOYER SR. — Address: RT#1 PETERSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sudden respiratory and circulatory failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hemorrhage in cerebral tumor or abcess — 48 hrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10/4 6 p.m. 19 59, to 10/5, 19 59, that I last saw the deceased alive on 10/4, 19 59, and that death occurred at 1 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. F. Abdullah, M.D
ADDRESS (Street, city or town, state): 132 N. Potomac
DATE SIGNED: 5 Oct 1959
PHYSICIAN'S NAME (Type): A. F. Abdullah — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/7/59
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM.
22d. LOCATION (City, town, or county) (State): FERDERICK MD.

23. FUNERAL DIRECTOR'S SIGNATURE: M. R. Etchison
ADDRESS: Frederick Md
24a. REC'D BY REGISTRAR DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11881 **CERTIFICATE OF DEATH** 11865

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 918 Mulberry Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 918 Mulberry Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First James Middle Marshall Last Brandt

4. DATE OF DEATH Month October Day 27 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 8, 1888
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Erector
10b. KIND OF BUSINESS OR INDUSTRY Organ
11. BIRTHPLACE (State or foreign country) Lebonon Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Brandt
14. MOTHER'S MAIDEN NAME Mary Foorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. 1
16. SOCIAL SECURITY NO 167-14-9487a
INFORMANT Address Mrs. Cora E. Brandt Hagerstown Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 10 min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Hypertensive Heart Disease 9 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954 to 10.27.59, 19, that I last saw the deceased alive on 10.25.59, 19, and that death occurred at 9.15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE S. Earl Young M.D.
ADDRESS (Street, city or town, state) 148 N. Potomac St. Hagerstown Md.
DATE SIGNED

PHYSICIAN'S NAME (Type) S. Earl Young

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-29-59
22c. NAME OF CEMETERY OR CREMATORY Ebenezar Cemetery
22d. LOCATION (City, town, or county) (State) Lebonon Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE OCT 30 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11882

CERTIFICATE OF DEATH

Reg. Dist. No. 302 — 11866

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: W sh County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 826 Oak Hill Avenue /Jackson Conv Home/
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST Middle SCHLOSSER Last BRINING

4. DATE OF DEATH: Month Oct Day 7 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 7 1870
9. AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jeweler
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Boonsboro Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward T. Brining
14. MOTHER'S MAIDEN NAME: Manzella Schlosser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Dorothy Brining 766 Northern Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO (b): Arteriosclerotic Heart Disease — 9 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hagerstown (County) Wash. (State) Md.

21. I certify that I attended the deceased from 11/17, 1939, to 10/7, 1959, that I last saw the deceased alive on 10/7, 1959, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H Hornbaker M D — ADDRESS (Street, city or town, state): 154 West Washington St. — DATE SIGNED:

PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Kinnard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11367

11883

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Pa. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle
d. STREET ADDRESS 50 S. Carlisle ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last BRUbaker

4. DATE OF DEATH Month Oct. Day 14 Year 1959

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June 7, 1886

9. AGE (In years last birthday) 73 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant

10b. KIND OF BUSINESS OR INDUSTRY Retired Storekeeper

11. BIRTHPLACE (State or foreign country) Upton, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm. Brubaker

14. MOTHER'S MAIDEN NAME Eliza Hawbaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 204-03-7793

17. INFORMANT Address Mrs. Margaret Brubaker - Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Gangrene Rt Leg — INTERVAL BETWEEN ONSET AND DEATH 1 mo

DUE TO (b) Diabetes Mellitus — 25 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Chronic Bronchiectasis — 15-20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio-Selerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19__, to 1959, 19__, that I last saw the deceased alive on Oct 14, 1959, and that death occurred at 11:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.

ADDRESS (Street, city or town) (State) Greencastle Pa.

DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) B.

22b. DATE THEREOF Oct. 17/59

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill

22d. LOCATION (City, town, or county) (State) Greencastle, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE A. E. Mummert - Greencastle, Pa.

ADDRESS

24a. REC'D BY REGISTRAR DATE OCT 19 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 2 11-2-59 ams

11884

CERTIFICATE OF DEATH

Reg. Dist. No. 11868

1. PLACE OF DEATH
a. COUNTY Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Butler

4. DATE OF DEATH Month 10 Day 24 Year 1959

5. SEX Male
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 6-8-1886
9. AGE (In years last birthday) 73 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Butler
14. MOTHER'S MAIDEN NAME Margaret Franklin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address Charles Butler Jr. Bristol Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sub-diaphragmatic abscess — INTERVAL BETWEEN ONSET AND DEATH: appr. x 3 Weeks
DUE TO (b) Gastric Carcinoma with Carcinomatosis — appx. 5 months
DUE TO (c) Carcinoma of stomach with carcinomatosis — 9 months

151 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 5, 1959, to Oct. 24, 1959, that I last saw the deceased alive on Oct. 24, 1959, and that death occurred at 9:30 AM, from the causes and on the date stated above

ACTUAL SIGNATURE Young E. Chun M.D.
ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave. Hagerstown, Md.
DATE SIGNED Oct 24 59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct 28 1959
22c. NAME OF CEMETERY OR CREMATORY Moses Society
22d. LOCATION (City, town or county) (State) Bristol Md.

23. FUNERAL DIRECTOR'S SIGNATURE Kirk Funeral Chapel Inc.
ADDRESS
24a. REC'D BY REGISTRAR DATE OCT 29 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11885

CERTIFICATE OF DEATH

Reg. Dist. No. 11869

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: about 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 102 E. Salisbury Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Harvey; Last: Byers

4. DATE OF DEATH: Month: Oct.; Day: 3; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 12 1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: 1; Days: 20
IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Auto Body Works

11. BIRTHPLACE (State or foreign country): Mercersburg Pa.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Edward Byers

14. MOTHER'S MAIDEN NAME: B. E. Sharer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214 09 3985

INFORMANT: Miss. Janice Byers
Address: 102 E. Salisburg St. Williamsport Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular hemorrhage with hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 ~~days~~ hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive arteriosclerotic heart disease — Unknown
DUE TO
(c):

I43X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m.; Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 23, 1958 19____, to October 3, 1959 19___, that I last saw the deceased alive on October 1, 1959, 19____ and that death occurred at 1:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D. — Clear Spring, Maryland — Oct. 5, 1959

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 6 1959
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf
ADDRESS: Williamsport, Md.

24a. RECEIVED BY REGISTRAR DATE: OCT 6 '59
24b. REGISTRAR'S SIGNATURE: L

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11886

CERTIFICATE OF DEATH

11870

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 42 E. Washington Street-
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle PEARL Last CARBAUGH

4. DATE OF DEATH: Month October Day 20 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 26, 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Knitter

10b. KIND OF BUSINESS OR INDUSTRY: Knitting Mill

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Semler

14. MOTHER'S MAIDEN NAME: Ida J. Lizer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Henry W. Carbaugh — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 17 days

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive cardiovascular disease — 21 months (certain)

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 3, 1959 to October 20 1959, that I last saw the deceased alive on October 20, 1959, and that death occurred at 6:50 P.M. DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. T. Layman, M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. Hagerstown Maryland — DATE SIGNED: 10/21/59

PHYSICIAN'S NAME (Type): William T. Layman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/23/1959

22c. NAME OF CEMETERY OR CREMATORY: Broadfording Cemetery

22d. LOCATION (City, town, or county) (State): Broadfording Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 28 59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11887

CERTIFICATE OF DEATH

11871 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 425 CLARENDON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE — Middle REBECCA — Last CHARLTON

4. DATE OF DEATH: Month OCTOBER — Day 1 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/10/1887

9. AGE (In years last birthday): 72 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN HENRY GORDON

14. MOTHER'S MAIDEN NAME: MARY LLOYD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-09-6674

INFORMANT: MRS. MARGARET HEAD

(Address): HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): decompensation — 2-3 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Hypertensive cardiovascular disease — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ① obesity ② Endometrial polyp.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 2, 1959, to Oct 1, 1959, that I last saw the deceased alive on Oct 1, 1959, and that death occurred at 9:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto M.D.

ADDRESS (Street, city or town, state): 217 W. Washington Street

DATE SIGNED: 10/2/59

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/3/59

22c NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment

ADDRESS: Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: OCT 2 '59

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11888 **CERTIFICATE OF DEATH** Reg. Dist. No. 11872

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 50yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d STREET ADDRESS: 230 N. Jonathan Street.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: (ne) — Last: Clark
4. DATE OF DEATH: Month: Oct — Day: 14 — Year: 19 59
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Feb 2 1887
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Eaklemill Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Millard F. Clark
14. MOTHER'S MAIDEN NAME: Josephine Callaman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Max Clark Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
331 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension Vascular Disease — 5 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-12-59, 19____, to 10-14-59, 19____, that I last saw the deceased alive on 10-14-59, 19____, and that death occurred at 10:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. E W Witt — M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/17/59
PHYSICIAN'S NAME (Type): DR E W WITT JR — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 17 1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md
24a. REC'D BY REGISTRAR DATE: OCT 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11889

11873

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution- Res dence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown
d. STREET ADDRESS: R.F.D. # 6
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First ROGER — Middle QUAY — Last COOK

4. DATE OF DEATH: Month October — Day 24 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 19, 1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cattle Breeder
10b. KIND OF BUSINESS OR INDUSTRY: own business
11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Cook
14. MOTHER'S MAIDEN NAME: Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
INFORMANT — Address: Mrs. Louise Cook Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dissecting aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Hypertensive arteriosclerotic disease — 4 years
DUE TO (c):

451X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary insufficiency

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 15, 1959, to Oct 24, 1959, that I last saw the deceased alive on Oct. 24, 1959, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. Stauffer, M.D. — ADDRESS (Street, city or town, state): 145 S. Prospect St — DATE SIGNED:

PHYSICIAN'S NAME (Type): R. S. STAUFFER — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/27/1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Houser Funeral Home — R. Franklin Houser
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: DATE NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Cathy E. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11874

11948

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GATEWAY NURSING HOME

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 119 E. LEE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle GRACE — Last CRIDER

4. DATE OF DEATH: Month OCTOBER — Day 29 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/18/1883

9 AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE BAKER

14. MOTHER'S MAIDEN NAME: AGNES KOONTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: NONE

INFORMANT: MR. WILLIAM H. CRIDER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiovascular Collapse
DUE TO (b): Arteriosclerosis Gen
DUE TO (c): Parkinson's Dis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: many yrs - many yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 59, to Oct 29, 19 59, that I last saw the deceased alive on Oct 25, 19 59, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis C. Grim M.D.
ADDRESS (Street, city or town, state): 119 E. Lee St. Hagerstown Md.
DATE SIGNED: 10/31/59
PHYSICIAN'S NAME (Type): Louis C. Grim

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 10/31/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Norment, Hagerstown Md

24a REC'D BY REGISTRAR DATE: NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 249 10-13-59 et

11875

CERTIFICATE OF DEATH

Reg. Dist. No. 11890

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 2020 Lexington Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Melvin — Last: Crosswhite

4. DATE OF DEATH: Month: 10 — Day: 4 — Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-5-1882 1881

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft

11. BIRTHPLACE (State or foreign country): Tenn.

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John M. Crosswhite

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-3415

INFORMANT: Mrs. Edna Pearl Crosswhite — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 7 months

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): acute cystitis, pyelitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 1959 to Oct. 4, 1959 that I last saw the deceased alive on Oct. 4, 1959, and that death occurred at 6:35 PM, DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: William T. Layman M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. Hagerstown, Maryland — DATE SIGNED: 10/5/59

PHYSICIAN'S NAME (Type): William T. Layman

22a BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-7-59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11876

11891 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 728 Antietam Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle RUSSELL — Last DAVIS
4. DATE OF DEATH: Month October — Day 4 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 11 1905
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lugger
10b. KIND OF BUSINESS OR INDUSTRY: Brandt Cabinet Wks
11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Davis
14. MOTHER'S MAIDEN NAME: Carrie Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 216-09-7863
17. INFORMANT: Mrs Dorothy C. Davis — Address: 728 Antietam Dr. Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Atherosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour — a.m. p.m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 4, 19 59, to Oct 4, 19 59, that I last saw the deceased alive on Oct 4, 19 59, and that death occurred at 7.45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John D Turco, M.D. — ADDRESS (Street, city or town, state): 302 N. Potomac St — DATE SIGNED:
PHYSICIAN'S NAME (Type): John D Turco — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/6/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR — DATE: OCT 8 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11949

CERTIFICATE OF DEATH

11877 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#5

c. LENGTH OF STAY IN 1b: 52 yrs.

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): X Rural Hagerstown R#5

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R#5 Hagerstown

d. STREET ADDRESS: R#5 Hagerstown

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSIAH Middle PETER Last DELAUTER

4. DATE OF DEATH: Month Oct. Day 12, Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov.6,1869

9. AGE (In years last birthday): 89 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Near Myersville,Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mahlon Delauter

14. MOTHER'S MAIDEN NAME: Elmira Gaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Forney Delauter Address: R#5 Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 12 years

420 A

DUE TO (b): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, cerebral and generalized.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1957, to October 12 1959 that I last saw the deceased alive on Sept. 24, 1959, and that death occurred at 9:30 P.M. DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. T. Layman, M.D — ADDRESS (Street city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 10/14/59

PHYSICIAN'S NAME (Type): William T. Layman Hagerstown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct.15,1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.

24a. REC'D BY REGISTRAR DATE: OCT 16 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

Wm. A. Hoot U. Bus.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11892

CERTIFICATE OF DEATH

11878

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BIG POOL
d. STREET ADDRESS: BIG POOL ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAYTON — Middle LEE — Last FARMER

4. DATE OF DEATH: Month IO — Day I4 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/I2/I895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRACKMAN
10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH FARMER
14. MOTHER'S MAIDEN NAME: ELIZABETH PAGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 70[illegible]-IO-8020
INFORMANT: MRS. CORA LEE FARMER — Address: BIG POOL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b): Thyroidectomy — 1 day.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hyperthyroidism — ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 19 59 to Oct 14, 19 59 that I last saw the deceased alive on Oct 13, 19 59, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md. — DATE SIGNED: 10/15/59

PHYSICIAN'S NAME (Type): David R Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: IO/I7/1959
22c. NAME OF CEMETERY OR CREMATORY: SHANKTOWN
22d. LOCATION (City, town, or county) (State): BIG POOL, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JOHN F. CLARK — ADDRESS: CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE: OCT 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11893

11879

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 105 E. Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARSHALL — Middle WADE — Last FITEZ

4. DATE OF DEATH: Month October — Day 15 — Year 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 28, 1877

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing salesman

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Emmittsburg, Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Fitez

14. MOTHER'S MAIDEN NAME: Mary Fogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-09-7353

17. INFORMANT: Paul R. Fitez — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

420.0

DUE TO (b) Arteriosclerotic Heart Disease. — 1 1/2 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9/27/57, 19____, to 10/15, 1959, that I last saw the deceased alive on 10/14, 1959, and that death occurred at 7:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Geo E Jennings M.D. — ADDRESS (Street, city or town, state): 136 W. Washington St — DATE SIGNED: 10/16/59

PHYSICIAN'S NAME (Type): George Jennings — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/17/1959

22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery

22d LOCATION (City, town, or county) (State): Newville, Pennsylvania

23 FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Charles L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11894 — 11880 — Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 145 So Potomac St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle NMN — Last FOSTER

4. DATE OF DEATH: Month October — Day 15 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jany 15 1893

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waiter

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Dardanells, Greece

12. CITIZEN OF WHAT COUNTRY? Greece ✓

13. FATHER'S NAME: Harry Foster

14. MOTHER'S MAIDEN NAME: Athena Tsaldaris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Trantulis — Address: 1037 Penna Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
DUE TO (b): Phlebothrombosis — 1 day
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
46 6 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS; HYPERTENSION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 29, 1959 to Oct 15, 1959, that I last saw the deceased alive on Oct 15, 1959, and that death occurred at 10:12 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Turco M.D. — ADDRESS (Street, city or town, state): 302 W. Potomac St — DATE SIGNED: 10-16 59

PHYSICIAN'S NAME (Type): JOHN D TURCO — Hagerstown, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b DATE THEREOF: 10/18/59 — 22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — 22d LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE OCT 19 '59 — 24b. REGISTRAR'S SIGNATURE: Cirilus L. Thoma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11895

CERTIFICATE OF DEATH

11881

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 year 10mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Church Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Shenandoah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Jackson
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALICE — Middle — Last FUNK

4. DATE OF DEATH: Month October — Day 21 — Year 19 59

5. SEX: fe male — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: December 6, 1872 — 9. AGE (In years last birthday): 86 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Moores Store, Virginia — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hopkins Ralston Funk — 14. MOTHER'S MAIDEN NAME: Elizabeth Andrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no — 16. SOCIAL SECURITY NO: none — 17. INFORMANT: Homewood Church Home — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: unk

420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): arteriosclertic heart dis — yr.

DUE TO (c): arteriosclerosis. — yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 20, 1959, to Oct 21, 19 59 that I last saw the deceased alive on Oct 21, 1959, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis G Graff M.D. — ADDRESS (Street, city or town, state): 119 E. Antrim — DATE SIGNED: 10/22/59

PHYSICIAN'S NAME (Type): Louis G. GRAFF — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/24/1959 — 22c. NAME OF CEMETERY OR CREMATORY: Solomon Church Cemetery — 22d. LOCATION (City, town, or county) (State): Shenandoah County, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Md. — 24a. REC'D BY REGISTRAR DATE: OCT 26 '59 — 24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11890 — 11882 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash Co Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [redacted] md Balto
d. STREET ADDRESS: 802 W. Fawcett St [redacted] Balto md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: — Last: Garrett

4. DATE OF DEATH: Month: 10 — Day: 3 — Year: 59 19

5. SEX: m

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 4 1890

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Potter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Beatrice Garrett 802 W. Fawcett St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion Cerebellar — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Atherosclerosis Severe

DUE TO

(c): Myocardial Infarct Recent — 10 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: o. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

EXAMINER'S NAME (Type): T. E. W. Hitt Jr

DATE SIGNED: 10/3/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-6-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington Mem

22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: George E. Nelson — ADDRESS: 1348 N. Calhoun St

24a. REC'D BY REGISTRAR — DATE: OCT 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11897

CERTIFICATE OF DEATH

Reg. Dist. No. 11883

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Res'dence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): 03 Hagerstown
d. STREET ADDRESS: 945 Chestnut St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Emory — Last: Gearhart

4. DATE OF DEATH: Month: 10 — Day: 17 — Year: 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 19, 1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: trackman W.M. R.R.
11. BIRTHPLACE (State or foreign country): Big Pool, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Gearhart
14. MOTHER'S MAIDEN NAME: Mary Trumpower

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Lena Miner — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 28½ hrs.
DUE TO (b): hypertensive cardiovascular disease — unknown
DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from October 16, 1959, to October 17, 1959 that I last saw the deceased alive an October 17, 1959, and that death occurred at 7:00 P.M. DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. T. Layman, M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 10/19/59

PHYSICIAN'S NAME (Type): William T. Layman — Hagerstown — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10-20-59
22c. NAME OF CEMETERY OR CREMATORY: Shanktown
22d. LOCATION (City, town, or county) (State): Shanktown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 21 '59
24b. REGISTRAR'S SIGNATURE: Cathryn L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11884

CERTIFICATE OF DEATH

11898 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL HAGERSTOWN
d. STREET ADDRESS: RT.#2 HAGERSTOWN MD.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ISAAC — Middle OTIS — Last GOOD

4. DATE OF DEATH: Month OCTOBER — Day 5 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3/21/1879

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: RAIL ROAD

11. BIRTHPLACE (State or foreign country): VIRGINIA

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: NOAH GOOD

14. MOTHER'S MAIDEN NAME: SUSAN ALESHIRE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service): NO

16 SOCIAL SECURITY NO: 705-10-6571

INFORMANT: MRS. DELIA GOOD — Address: RT.#2 HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinoma recto-sigmoid c	6 Mos
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	perforation of bowel and	7 Days
DUE TO (c)	Generalized peritonitis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign Prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a m / p m, 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 3, 1959, to Oct 5, 1959, that I last saw the deceased alive on Oct 5, 1959, and that death occurred at 10 30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto M.D. — ADDRESS (Street, city or town, state): 217 W. Washington Street — DATE SIGNED: 10-6-59

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/7/59

22c. NAME OF CEMETERY OR CREMATORY: SALEM REFORMED CHURCH

22d. LOCATION (City, town, or county) (State): WASHINGTON CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment, Hagerstown, Md. — ADDRESS

24a. REC'D BY REGISTRAR — DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Stone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11899

CERTIFICATE OF DEATH

11885

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 831 Oak Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BYRON; Middle: JUDSON; Last: GRIMES

4. DATE OF DEATH: Month: October; Day: 1; Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Superentendent

10b KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Lightstreet, Penn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Emory

14. MOTHER'S MAIDEN NAME: Mary E. Merrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Elizabeth M. Grimes — Address: Montclair, N. J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (a)) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(b) with Cerebral hemorrhage — 5 days
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 25, 19 21 to Oct 1, 19 59, that I last saw the deceased alive on Sept 30, 19 59, and that death occurred at 12:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Wilhelm M.D. — ADDRESS (Street, city or town, state): Hagerstown — DATE SIGNED: 10/3/59

PHYSICIAN'S NAME (Type): G. Wilhelm Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/3/1959

22c. NAME OF CEMETERY OR CREMATORY: Lightstreet Cemetery

22d LOCATION (City, town, or county) (State): Lightstreet, Penn.

23. FUNERAL DIRECTOR'S SIGNATURE: Sutter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.
F. Franklin Rouzer

24a. REC'D BY REGISTRAR DATE: OCT 7 '59

24b REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to Burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11900 11886

Reg. Dist. No. 301

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 224 Summers Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RONALD; Middle EUGENE; Last GROSS

4. DATE OF DEATH: Month October; Day 14; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 23, 1950

9. AGE (In years last birthday): 9 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Francis Gerald Gross

14. MOTHER'S MAIDEN NAME: Alice May Dunkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Francis G. Gross — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Contusion of Scalp — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Acute Epidural Hemorrhage Left Frontal — 40 Hours

DUE TO (c): Pulmonary Congestion

910.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): struck by stone thrown by playmate

20c. TIME OF INJURY: Hour 2 p.m.; Month, Day, Year: 10-13 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): street

20f. (City or town): Hagerstown (County): Washington (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): J. D. E. W. H. T. Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10/16/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/18/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11887

CERTIFICATE OF DEATH

11901 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 621 Maryland Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 621 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harvey — Middle Windfield — Last Grove

4. DATE OF DEATH: Month October — Day 9 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jany 10 1883

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Big Pool Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Grove

14. MOTHER'S MAIDEN NAME: Susan Pine

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-14-2573

17. INFORMANT: Anna Wilke — Address: 4972 Jefferson St Bellaire Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

DUE TO (b): Possible Coronary Thrombosis — 2 weeks

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-20-59, to 10-9-59, 1959, that I last saw the deceased alive on 10-9-59, 19, and that death occurred at 7 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D W Coffman M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10 Oct 59

PHYSICIAN'S NAME (Type): Dr E W Coffman Jr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/12/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: OCT 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11902 11888

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 53 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 804 Woodland Way

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 804 Woodland Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Evelyn — Middle Louise — Last Harbaugh

4. DATE OF DEATH: Month October — Day 6, — Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 18, 1906

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): clerk

10b. KIND OF BUSINESS OR INDUSTRY: ladies Dept. Store

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Luther Minnich

14. MOTHER'S MAIDEN NAME: Florence Leiter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

INFORMANT — Address: Paul Harbaugh, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Arteriosclerotic Heart Disease 7 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 min

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1941, 19___, to 10-6-59, 19___, that I last saw the deceased alive on 10-6-59, 19___, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E Caulfoung M.D. — ADDRESS (Street, city or town, state): 148 W. Potomac St. — DATE SIGNED

PHYSICIAN'S NAME (Type): SEARL YOUNG MD, Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-8-59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11903

11889 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 706 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LUCY — Middle: EDNA — Last: HARBAUGH

4. DATE OF DEATH: Month: October — Day: 31 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October, 17, 1887

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fairfield, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Stahley

14. MOTHER'S MAIDEN NAME: Margaret McIntire

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

INFORMANT: Mr. A. A. Harbaugh — Address: 706 W. Washington St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO (b): arteriosclerosis — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Nephrosclerosis BP 24-0 — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 4, 19[illegible] to Oct 31, 19[illegible], that I last saw the deceased alive on Oct 31, 19[illegible], and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. — ADDRESS (Street, city or town, state): P 159 W. Washington St., Hagerstown, Md. — DATE SIGNED: 11/2/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 3, 1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.
Wm. C. Hott

24a. REC'D BY REGISTRAR DATE: NOV 4 '59

24b. REGISTRAR'S SIGNATURE: Cletus S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11904 **CERTIFICATE OF DEATH** Reg. Dist. No. 11890

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 29 years
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d STREET ADDRESS: 114 Wayside Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edna Middle: Catherine Last: Harris
4. DATE OF DEATH: Month: October Day: 27 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 17, 1890
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Westminister Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward F. Huff
14. MOTHER'S MAIDEN NAME: Mary E. Addleperger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-18-0751
INFORMANT: Edward G. Harris Address: Hagerstown Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic Carcinoma - Liver — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.
153.3
DUE TO (b): Carcinoma Sigmoid — 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertension Cerebrovascular Disease — 9 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1931, to Oct 27, 1959, that I last saw the deceased alive on Oct 27, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jno. P. Hirshman M.D.
ADDRESS (Street, city or town, state): 159 West Washington St.
DATE SIGNED: 10/28/59

PHYSICIAN'S NAME (Type): P. J. Hirshman, M.D. Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-30-59
22c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
22d. LOCATION (City, town, or county) (State): Littlestown Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 30 '59
24b. REGISTRAR'S SIGNATURE: Cathy L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11905

CERTIFICATE OF DEATH

11891
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1000 Madison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Annie Middle Louisa Last Hibberd

4. DATE OF DEATH: Month Oct. Day 13 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 8, 1897
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Helwig
14. MOTHER'S MAIDEN NAME: Katherine Nine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
INFORMANT: Mr. Raymond M Hibberd- Son- Same as # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): 40 Lymphatic Leukemia — 5 years
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Bronchiectasis 2) Pulmonary emphysema
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 9, 1959 to October 13, 1959 that I last saw the deceased alive on October 13, 1959, and that death occurred at 1:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George Bercu M.D.
ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE HAGERSTOWN, MARYLAND
DATE SIGNED: 10/13/59
PHYSICIAN'S NAME (Type): DR. GEORGE BERCU

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Fil'd 11-4-59 et

11906

CERTIFICATE OF DEATH

11892 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Roy — Middle Hipp — Last
4. DATE OF DEATH: Month Oct. — Day 29 — Year 1959

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1925 — 1-28-1924
9. AGE (In years last birthday): 34 Yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool Sharpener
10b. KIND OF BUSINESS OR INDUSTRY: Black Top Co.
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis E. Hipp
14. MOTHER'S MAIDEN NAME: Minnie Aldrich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service): World War 2
16. SOCIAL SECURITY NO.: 242-40-3649
INFORMANT — Address: John Mooney, Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Pulmonary edema	5 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	uremia	7 days
DUE TO (c)	Lupus erythematosus Dessiminatus	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute pericarditis probably rheumatic in origin

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 28, 1959, to October 29, 1959 that I last saw the deceased alive on October 29, 1959, and that death occurred at 2:25 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Victor L. Ramos, M.D — ADDRESS (Street, city or town, state): Western Md. State Hospital — DATE SIGNED: Oct. 30, 1959

PHYSICIAN'S NAME (Type): VICTOR L. Ramos — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 1-1959
22c. NAME OF CEMETERY OR CREMATORY: Baptist cemetery
22d. LOCATION (City, town, or county) (State): Manchester Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw A Tipton — ADDRESS: Hampstead Md
24a. REC'D BY REGISTRAR DATE: NOV 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11907

CERTIFICATE OF DEATH

Reg. Dist. No. 11893

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg
d. STREET ADDRESS: 23 S. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: — Last: Hollingsworth

4. DATE OF DEATH: Month: Oct. — Day: 19 — Year: 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): owner

10b. KIND OF BUSINESS OR INDUSTRY: conf. store

11. BIRTHPLACE (State or foreign country): Smithsburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Hollingsworth

14. MOTHER'S MAIDEN NAME: Anna B. Barkdoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 220-09-9064

INFORMANT: Mrs. Bertha Hollingsworth, Address: Smithsburg,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

541.0

DUE TO (b): Ruptured Duodenal Ulcer — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Psychoneurosis — 5 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-4, 1957, to 10-19, 1959, that I last saw the deceased alive on 10-19, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Hess M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 10-21-59

PHYSICIAN'S NAME (Type): Charles F. Hess M.D. — Smithsburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-22-59

22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR DATE: OCT 23 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11908

Reg. Dist. No. 302 11894

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 415 Guilford Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STELLA Middle IRENE Last HORT

4. DATE OF DEATH: Month October Day 9 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1875
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): near Danville, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Savage
14. MOTHER'S MAIDEN NAME: Johanna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Velma Gamby Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 4 hrs

DUE TO (b) Arteriosclerotic Heart Disease — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Heart Disease — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1945 19____ to 10/9/59 19____, that I last saw the deceased alive on 10/9/59 19____, and that death occurred at 11.45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Hagerstown, Md DATE SIGNED: 10/10/59

PHYSICIAN'S NAME (Type): SEARL YOUNG MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/12/1959
22c. NAME OF CEMETERY OR CREMATORY: Rush Baptist Church Cem.
22d. LOCATION (City, town, or county) (State): Danville, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Kreps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11909

CERTIFICATE OF DEATH

11895
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 20 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 207 ALEXANDER ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): J. HAGERSTOWN
d. STREET ADDRESS: 207 ALEXANDER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HARVEY HUNTZBERRY Last

4. DATE OF DEATH: Month OCTOBER Day 7 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 6 1875
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months 5 Days 1
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FRUIT GROWER AND CARRIAGE PAINTER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): SMITHSBURG WASH. CO. MD
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN HUNTZBERRY
14 MOTHER'S MAIDEN NAME: ELIZABETH DIAMOND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: NONE
INFORMANT: ELMER HUNTZBERRY Address: 207 ALEXANDER ST HAGERSTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia + B.U. Bleeding — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
177X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Prostate — 3 YRS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 1958, to Oct 1959, that I last saw the deceased alive on Oct 7 1959, and that death occurred at 4 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Tucci M.D. ADDRESS (Street, city or town, state): 302 N. POTOMAC ST DATE SIGNED: 10-7 59
PHYSICIAN'S NAME (Type): JOHN D. TUCCI HAGERSTOWN, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 9. 1959
22c. NAME OF CEMETERY OR CREMATORY: FAHRNEY'S CEMETERY
22d. LOCATION (City, town, or county) (State): MAPLEVILLE WASH. CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John D Bast ADDRESS: BOONSBORO MD
24a REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11896 Reg. Dist. No. 11950

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Spielman Station
c. LENGTH OF STAY IN 1b 38 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairplay Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Spielman Station
d. STREET ADDRESS Fairplay Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Myrtle Middle: Amelia Last: Hutzell
4. DATE OF DEATH Month: Oct. Day: 4 Year: 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 7 1894
9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months 0 Days 27 IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (State or foreign country) Tilghmanton Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Hezekiah Moats
14. MOTHER'S MAIDEN NAME Annie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 219 20 3419
17. INFORMANT Mr. Edward Hutzell Address: Spielman Station Fairplay Md RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9140
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Electrocution — Interval between onset and death: Instant
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II or item 18.) Electrocuted while taking bath in tub
20c. TIME OF INJURY Hour 5 o. m. p. m. Month, Day, Year 10/4/59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Fairplay (County) Washington (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. W. Ditto, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.
DATE SIGNED 10/5/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 7 1959
22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery
22d. LOCATION (City, town, or county) (State) Boonsboro Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leap ADDRESS Williamsport, Md
24a. REC'D BY REGISTRAR DATE OCT 8 '59
24b. REGISTRAR'S SIGNATURE Arthur A. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11910 **CERTIFICATE OF DEATH** Reg. Dist. No. 11897

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital 21

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 214 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nora — Middle Swisher — Last Izer
4. DATE OF DEATH: Month October — Day 26, — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 20, 1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Washington Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Swisher
14. MOTHER'S MAIDEN NAME: Loula Belle Trovinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Lauren B. Izer R.D.# 3 Greencastle, Pa. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS, GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
DUE TO
(b): ADENOCARCINOMA OF THE BREAST, BILATERAL — 4 YEARS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour ___ o. m. p. m. Month ___ Day ___ Year 19___
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from FEB 1, 1955, 19___, to OCT. 26, 1959 19___, that I last saw the deceased alive on OCT. 26, 1959, 19___, and that death occurred at 11.50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.
ADDRESS (Street, city or town, state): CLEAR SPRING, MARYLAND
DATE SIGNED: 10-27-59
PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-30-1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county) (State): Greencastle, Franklin Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman
ADDRESS: Greencastle Pa
24a. REC'D BY REGISTRAR DATE: OCT 30 '59
24b. REGISTRAR'S SIGNATURE: Clint S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11898

11911

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 55 East Ave

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 55 East Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MARY Last LONG

4. DATE OF DEATH: Month October Day 2 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 5 1876

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pa Chambersburg Franklin Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Sensheimer

14. MOTHER'S MAIDEN NAME: Margaret Smith

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Jean Rider
Address: 55 East Ave H gerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
(b): Generalized arteriosclerosis — Unknown
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19, 1954, to Oct 2, 1959, that I last saw the deceased alive on Oct. 2, 1959, and that death occurred at 10 a.m. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. L Packer Jr M.D.
ADDRESS (Street, city or town, state): 145 W. Washington St
DATE SIGNED: 10/3/59

PHYSICIAN'S NAME (Type): L. L. Packer Jr
Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/5/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur S Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11899

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.
c. LENGTH OF STAY IN 1b one day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 414 Guilford Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Altoona 75X-3
d. STREET ADDRESS 1118 14 E. Ave. Altoona Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Harry Middle Irvin Last Lumm Jr.
4. DATE OF DEATH Month Oct. Day 24 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan. 10 1910
9. AGE (In years last birthday) 49 yrs.
IF UNDER 1 YEAR: Months 9 Days 13
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY School Supplies
11. BIRTHPLACE (State or foreign country) Bakersville Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Harry Irvin Lumm Sr.
14. MOTHER'S MAIDEN NAME Maude Vickers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 2
16. SOCIAL SECURITY NO. 214 09 7748
17. INFORMANT Mr. Harry Lumm Sr. Address 414 Guilford Ave. Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH instant

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardio Vascular Disease — 6 year
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE J. E. Whitto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) J E WHITTO Jr
DATE SIGNED 10/29/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 27-59
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery
22d. LOCATION (City, town, or county) (State) Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]
24a. REC'D BY REGISTRAR DATE OCT 28 '59
24b. REGISTRAR'S SIGNATURE Clifton L. Heard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director who will see that it is forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11913 **CERTIFICATE OF DEATH** Reg. Dist. No. 11900

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. N. J. — b. COUNTY: Monmouth
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Beach
d. STREET ADDRESS: 333 Lorillard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle Dolores — Last Lutz
4. DATE OF DEATH: Month Oct. — Day 28, — Year 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 2, 1930
9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waitress
10b. KIND OF BUSINESS OR INDUSTRY: resturant
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry D. Meyers
14. MOTHER'S MAIDEN NAME: Luretta Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 215-26-1430
INFORMANT: William Lutz, Union Beach, N.J. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
174X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/24, 19 59, to Oct 28, 19 59, that I last saw the deceased alive on Oct 28, 19 59, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison, M.D. — ADDRESS (Street, city or town, state): 318 North Potomac St — DATE SIGNED
PHYSICIAN'S NAME (Type): Paul Harrison, M.D. — Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): cremation
22b. DATE THEREOF: 10-31-59
22c. NAME OF CEMETERY OR CREMATORY: Green Mount Crematory
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: OCT 30 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914

CERTIFICATE OF DEATH

11901 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
d. STREET ADDRESS: SOUTH MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle CLARK Last MACMULLAN

4. DATE OF DEATH: Month OCTOBER Day 1 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 22-1870
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months 0 Days 9
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): PRINCE GEORGES Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: STEPHEN CLARK
14. MOTHER'S MAIDEN NAME: ELIZABETH WATSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
INFORMANT: CHARLES F MACMULLAN JR Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Chronic Lithiasis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Pneumonitis. — 7 days
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 18, 1959, to October 1, 1959, that I last saw the deceased alive on Sept 30, 1959, and that death occurred at 2 A. M., from the causes and on the date stated above

ACTUAL SIGNATURE: J. W. Lidard M D
ADDRESS (Street, city or town, state): Boonsboro
DATE SIGNED: 10/3/59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: OCT. 3 1959
22c. NAME OF CEMETERY OR CREMATORY: ST. MARKS CEMETERY
22d. LOCATION (City, town, or county) (State): LAPPANS WASH. Co. MD.

23 FUNERAL DIRECTOR'S SIGNATURE: John H. Baird
ADDRESS: BOONSBORO MD
24a REC'D BY REGISTRAR DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11902

11915

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 70 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): C.3 Hagerstown
d. STREET ADDRESS: 165 Madison Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Roger — Last: Marmaduke

4. DATE OF DEATH: Month: Oct — Day: 4 — Year: 1959

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 4, 1869 — 9. AGE (In years last birthday): 90 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (State or foreign country): Tilghmanton Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Marmaduke
14. MOTHER'S MAIDEN NAME: Alice Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 220-18-0479
INFORMANT: Joseph W. Marmaduke — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure and pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — 2 years (certain)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 25, 1959 to Oct. 4, 1959, that I last saw the deceased alive on Oct. 3, 1959, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Layman, M.D. — ADDRESS (Street, city or town, state): 15 Public Square — DATE SIGNED:

PHYSICIAN'S NAME (Type): William T. Layman — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-6-59
22c. NAME OF CEMETERY OR CREMATORY: Bakersville Cemetery
22d. LOCATION (City, town, or county) (State): Bakersville Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 7 '59
24b. REGISTRAR'S SIGNATURE: Calvin S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11916

CERTIFICATE OF DEATH

11903

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
c. LENGTH OF STAY IN 1b: 10yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.
d. STREET ADDRESS: 329 N. Jonathan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Thomas Middle Nelson Last Mason

4. DATE OF DEATH: Month Oct. Day 2 Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 17 1903

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY: County Club

11. BIRTHPLACE (State or foreign country): Jamestown, W.Va.,

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William Mason

14. MOTHER'S MAIDEN NAME: Unknow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 228-18-6388

INFORMANT: Walter Mason Address: 230. N. Jonathan St.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

466x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Phlebothrombosis, bilateral — 7 days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ① Cerebro vaseular accident ② Rt. hemiphlegia ③ Hypertensive Heart Disea

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from Sept. 30, 1959, to OCTOBER 2, 1959 that I last saw the deceased alive on October 2, 1959, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. ADDRESS (Street, city or town, state): Western md. state Hospital DATE SIGNED: Oct. 2, 1959

PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 7 1959

22c. NAME OF CEMETERY OR CREMATORY: Jamestown Cemetery

22d. LOCATION (City, town, or county) (State): Jamestown, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson ADDRESS: Hagerstown Md,

24a. REC'D BY REGISTRAR DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11917

CERTIFICATE OF DEATH

Reg. Dist. No. 11904 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Martin Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Hagerstown.
d. STREET ADDRESS: 1021 Concord St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEARL — Middle BLANCHE — Last MATEER

4. DATE OF DEATH: Month October — Day 14 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 6 1890
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Job Randolph Co W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Summerfield
14. MOTHER'S MAIDEN NAME: Lora B. Montoney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO: None
17. INFORMANT: William A Mateer — Address: 100½ So 5th St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — Chambersburg Pa.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio-Renal Disease — 15 MONTHS
DUE TO (c):

442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Vascular accident

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from JULY, 1958, to OCT, 1959, that I last saw the deceased alive on OCT 14, 1959, and that death occurred at 3:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Turco M.D. — ADDRESS (Street, city or town, state): 302. N. POTOMAC ST — DATE SIGNED: 10-14-59

PHYSICIAN'S NAME (Type): JOHN D. TURCO — HAGERSTOWN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/17/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR DATE: OCT 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11918

11905

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 155 Summit Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Middle Last: [illegible] Katherine McNamee
4. DATE OF DEATH: Month: Oct — Day: 6 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 28, 1902
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Neikirk
14. MOTHER'S MAIDEN NAME: Emma J. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT: Mr. Charles W. Mc Namee — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 8 HOURS
420.1
DUE TO (b): MYOCARDIAL INFARCTION, OLD — 17 YEARS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): AMYOTROPHIC LATERAL SCLEROSIS. HYPERTENSIVE CARDIO-VASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 5, 1959, to October 6, 1959 that I last saw the deceased alive on October 6, 1959, and that death occurred at 7:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George Bacu, M.D. — ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE HAGERSTOWN, MARYLAND — DATE SIGNED: 10/7/59
PHYSICIAN'S NAME (Type): DR. GEORGE BERCU

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/9/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Gardens
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Couzer Funeral Home — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: DATE OCT 13 '59
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11919

CERTIFICATE OF DEATH

Reg. Dist. No. 11906

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. — b. COUNTY: Berkeley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falling Waters W. Va. RFD
d. STREET ADDRESS: Marlowe
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Frazier — Middle Lee — Last Miller
4. DATE OF DEATH: Month Oct. — Day 27 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 2 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months 9 — Days 23
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Harvey Miller
14. MOTHER'S MAIDEN NAME: Anna Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 236 56 3753
INFORMANT: Mr. Kenneth Miller — Address: Marlowe RFD Falling Waters W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
331 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m.
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10/26/59 to 10/27/59, that I last saw the deceased alive on 10/27/59, and that death occurred at 2:30 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Ralph Young M.D — ADDRESS (Street, city or town, state): Williamsport Md — DATE SIGNED: 10/27/59
PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 29-59
22c NAME OF CEMETERY OR CREMATORY: Harmony Cemetery
22d. LOCATION (City, town, or county) (State): Near Marlowe W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert R. Leap — ADDRESS: Williamsport, Md
24a. REC'D BY REGISTRAR DATE: NOV 2 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11951 — Reg. Dist No. 11997

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TILGHMANTON RURAL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BOONSBORO MD. R1

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TILGHMANTON RURAL
d. STREET ADDRESS: BOONSBORO. MD. R 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle EDWARD — Last MOATS

4. DATE OF DEATH: Month OCTOBER — Day 26 — Year 19 59

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: FEB. 1 1879 — 9. AGE (In years last birthday): 80 yrs — IF UNDER 1 YEAR: Months 8 Days 25 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER — 10b. KIND OF BUSINESS OR INDUSTRY: FARM WORK — 11. BIRTHPLACE (State or foreign country): TILGHMANTON WASH. CO. MD. U.S.A. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JACOB MOATS — 14. MOTHER'S MAIDEN NAME: ANNA MONCAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: 217-10-2918 — 17. INFORMANT: MRS. REBA NAVE — Address: BOONSBORO MD R2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 420.0

DUE TO (b): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour ... a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): DR. E. W. DITTOE — DATE SIGNED: 10/27/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: Oct. 30 1959 — 22c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY — 22d. LOCATION (City, town, or county) (State): NR. TILGHMANTON WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Obert — ADDRESS: BOONSBORO MD. — 24a. REC'D BY REGISTRAR DATE: NOV 3 '59 — 24b. REGISTRAR'S SIGNATURE: Clinton R. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11920

Reg. Dist. No. 11998

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT. CARMEL - RURAL
d. STREET ADDRESS: 1 BOONSBORO MD. R.2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: DENNIS Middle: ELBERT Last: MOSER
4. DATE OF DEATH: Month: OCTOBER Day: 20 Year: 19 59

5 SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: OCTOBER 20 1959
9. AGE (In years last birthday): —
IF UNDER 1 YEAR: Months —, Days —
IF UNDER 24 HRS: Hours 18, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): HAGERSTOWN MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELBERT MOSER
14. MOTHER'S MAIDEN NAME: MARLENE ROUTZAHN

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: NONE
INFORMANT: ELBERT MOSER Address: BOONSBORO MD. R.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 10 Days
DUE TO
776 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 20, 19 59, to Oct 20, 59, 19 ___, that I last saw the deceased alive on Oct. 22, 19 59, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D.
ADDRESS (Street, city or town, state): Boonsboro
DATE SIGNED: 10/21/59
PHYSICIAN'S NAME (Type): G. W. LeVan
Hist.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 22 - 59
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Best
ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE: OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Caitlin S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11921

CERTIFICATE OF DEATH

Reg. Dist. No. 11910

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 16 Conococheague St.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Carrie; Middle Rhea; Last Murray

4. DATE OF DEATH: Month Oct. Day 30 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 24 1898

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months 7 Days 5
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Near Downsville Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Clayton Cline

14. MOTHER'S MAIDEN NAME: Florence Wolford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

INFORMANT: 18 N. Address Conococheague St
Mr. William Murray Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Hypertension — 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 30, 1959, to Oct 30, 1959 that I lost saw the deceased alive on Oct 30, 1959 and that death occurred at 3:22 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M E Byrkit M.D
ADDRESS (Street, city or town, state): 28 W Potomac
DATE SIGNED: 10-31-59

PHYSICIAN'S NAME (Type): M. E. Byrkit Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 2 1959
22c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf
ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: NOV 3 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11922

Reg. Dist. No. 1911

1. PLACE OF DEATH
a. COUNTY WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MARYLAND STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MARYLAND — b. COUNTY MONTGOMERY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS: 705 RITCHIE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALVIN — Middle RUDOLPH — Last NAECKER

4. DATE OF DEATH: Month OCTOBER — Day 18 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11/22/04

9. AGE (In years last birthday): 54 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Piano Tuner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES H. A. NAECKER

14. MOTHER'S MAIDEN NAME: EMMA LOUISE CLARK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 578-05-9676

INFORMANT — Address: Mrs. Homer J. Booth, 858 Venable Pl., N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE & ASPIRATION OF BLOOD — INTERVAL BETWEEN ONSET AND DEATH: 10 MINUTES

144X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) PULMONARY CONGESTION & EDEMA — 2 HOURS

DUE TO (c) SQUAMOUS CELL CARCINOMA OF MOUTH WITH EXTENSION TO NECK, 15 MOS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 30, 1959, to OCTOBER 18, 1959, that I last saw the deceased alive on OCTOBER 18, 1959, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George Bercu M.D — ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE — DATE SIGNED: 10/19/59

PHYSICIAN'S NAME (Type) DR. GEORGE BERCU — HAGERSTOWN, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 10/21/59

22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY

22d LOCATION (City, town, or county) (State): PRINCE GEO. COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: WARNER E. PUMPHREY, INC. Raymond A Zinke. — ADDRESS: SILVER SPRING, MD.

24a REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11923

CERTIFICATE OF DEATH

11912
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JACKSON CONV. HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MAUGANSVILLE
d STREET ADDRESS: 1 SUNRISE DRIVE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

C43

3 NAME OF DECEASED (Type or print): First CARRIE — Middle ELZIE — Last NICODEMUS

4. DATE OF DEATH: Month OCTOBER — Day 27 — Year 19 59

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 27 1879

9. AGE (In years last birthday): 79 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: W. HENRY CRIM

14. MOTHER'S MAIDEN NAME: REBECCA ROWLAND

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: NO

16. SOCIAL SECURITY NO: 219-20-3555

INFORMANT: MRS. MARGUERITE KERLIN — Address: MAUGANSVILLE MD.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis, cerebral and generalized — INTERVAL BETWEEN ONSET AND DEATH: 2 years
334X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus; fracture intertrochanteric

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Patient stood, twisted foot under chair and fell.

20c TIME OF INJURY Month, Day, Year: 9:45 a.m. p.m. July 20 1959

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — 20f. (City or town) Maugansville — (County) — (State) Maryland

21. I certify that I attended the deceased from July 20, 19 59, to October 27 19 59 that I last saw the deceased alive on October 26, 19 59, and that death occurred at 2:10 P.M. EST, from the causes ond on the date stated above.

ACTUAL SIGNATURE: W. D. Layman, M.D. — M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. — DATE SIGNED: 10/28/59

PHYSICIAN'S NAME (Type): William T. Layman — Hagerstown — Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-30-59

22c. NAME OF CEMETERY OR CREMATORY: PARK HEIGHTS CEM.

22d. LOCATION (City, town, or county) (State): BRUNSWICK MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: NOV 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924 11913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: Williamsport Sanitarium
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles Middle: Custer Last: Powell

4. DATE OF DEATH: Month: 10 Day: 11 Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1890

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: R.R. Watchman

11. BIRTHPLACE (State or foreign country): Preston Co. W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Amasac C. Powell

14. MOTHER'S MAIDEN NAME: Elizabeth V. Golf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Hattie Hebb Address: 312 Poplar St Parsons, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
792 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1958, to Oct 10, 1958, that I last saw the deceased alive on Oct. 10, 1959, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Max E. Byrkit M.D. ADDRESS (Street, city or town, state): 28 W. Potomac Street DATE SIGNED:

PHYSICIAN'S NAME (Type): Max E. Byrkit, M.D. Williamsport, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct.13,1959
22c. NAME OF CEMETERY OR CREMATORY: Macedonia Cemetery
22d. LOCATION (City, town, or county) (State): St. George, West Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Greenlief Funeral Home Parsons, W. Va.

24a. REC'D BY REGISTRAR DATE: OCT 22 '59

24b. REGISTRAR'S SIGNATURE: Gaither L. Krauss

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11914

11925

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASH. CO. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: WASH.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × RURAL CLEAR SPRING
d. STREET ADDRESS: CLEAR SPRING RT I
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle ADAM Last REPP

4. DATE OF DEATH: Month IO Day 1 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 24, 1921

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TOOL AND DYE MAKER

10b. KIND OF BUSINESS OR INDUSTRY: AIRCRAFT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EARL R. REPP

14. MOTHER'S MAIDEN NAME: ANNIE M. McKEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): II

16. SOCIAL SECURITY NO.: 214-16-2604

INFORMANT: MRS. MILDRED I. REPP Address: CLEAR SPRING, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperpyrexia — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

193.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Glioma right thalamus — 13 months (history)

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Complete left-sided hemiplegia due to glioma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ____ a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 30, 1959, to October 1, 1959, that I last saw the deceased alive on October 1, 1959, and that death occurred at 10:50 A. M. DST, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. T. Layman M.D.

ADDRESS (Street, city or town, state): 100 Professional Arts Bldg.

DATE SIGNED: 10/2/59

PHYSICIAN'S NAME (Type): William T. Layman Hagerstown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/4/59

22c. NAME OF CEMETERY OR CREMATORY: BLAIRS VALLEY CEMETERY

22d. LOCATION (City, town, or county) (State): CLEAR SPRING, MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: JOHN F. CLARK CLEAR SPRING, MD.

24a. REC'D BY REGISTRAR DATE: OCT 5 '59

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11926

CERTIFICATE OF DEATH

11915
Reg. Dist No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryand — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d STREET ADDRESS: 25 N. Docust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: May — Last: Rice

4. DATE OF DEATH: Month: Oct. — Day: 27 — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 9 1879
9. AGE (In years last birthday): 80 yrs — IF UNDER 1 YEAR: Months: 0 Days: 17 — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Shepherdstown W. Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Do not know
14. MOTHER'S MAIDEN NAME: Do not Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
INFORMANT: Mrs. Mary Rice — Address: 25 N. Locust St, Hagerstown Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: min

DUE TO (b): Coronary Occlusion — days

DUE TO (c): Arteriosclerosis — yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastroenteritis — Diabetes — Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 19 55 to Oct 27, 1959, that I last saw the deceased alive on Oct 27, 19 59, and that death occurred at 7:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis S. Graff M.D. — ADDRESS (Street, city or town, state): 119 E. [illegible] — DATE SIGNED: 10-31

PHYSICIAN'S NAME (Type): Louis G. Graff

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 30-59
22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
22d LOCATION (City, town, or county) (State): Near Marlowe W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Lisk — ADDRESS: Williamsport Md.

24a. REC'D BY REGISTRAR: DATE NOV 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11916

11927 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: W. Va. b. COUNTY: Morgan

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 30 days

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berkeley Springs

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Hospital

d STREET ADDRESS: 802 James Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paige Middle: Leona Last: Roach

4. DATE OF DEATH: Month: October Day: I3, Year: 1959

5 SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. II, I927

9 AGE (In years last birthday): 32 yrs

IF UNDER 1 YEAR Months: 2 Days: 2 IF UNDER 24 HRS Hours: Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: -------

11 BIRTHPLACE (State or foreign country): Morgan County, W. Va.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Odis Kelly

14. MOTHER'S MAIDEN NAME: Odessa Bohrer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 235-32-208I

17. INFORMANT: Henry M. Roach Jr. Address: 802 James St. Berkeley Springs W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

193.0

DUE TO (b): Increased Intracranial pressure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Brain tumor - malignant (verified at operation) 6- Mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 14, 1922, to October 13, 1959 that I last saw the deceased alive on October 12, 1959, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. F. Abdullah M.D. ADDRESS (Street, city or town, state): 132 N. Potomac DATE SIGNED: 10/17/59

PHYSICIAN'S NAME (Type): A. F. Abdullah MD I32 N. Potomac St., Hagerstown, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: I0/I5/59

22c. NAME OF CEMETERY OR CREMATORY: Greenway

22d LOCATION (City, town, or county) (State): Berkeley Spgs. W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Parks ADDRESS: PARKS FUNERAL HOME, Berkeley Spgs. W. Va.

24a. REC'D BY REGISTRAR DATE: OCT 20 '59

24b. REGISTRAR'S SIGNATURE: Carlton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11928

CERTIFICATE OF DEATH

Reg. Dist. No. 11917

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TILGHMANTON RURAL
d. STREET ADDRESS: BOONSBORO MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLADYS Middle H. Last REHRER

4. DATE OF DEATH: Month OCTOBER Day 2 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 4 - 1903
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country): SAMPLES MANOR WASH. Co. MD. U.S.A.
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE W. ROHRER
14. MOTHER'S MAIDEN NAME: VADA MYERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-24-7727
INFORMANT: MRS. EDGAR BLACK JR. Address: BOONSBORO MD R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis of the left internal carotid — INTERVAL BETWEEN ONSET AND DEATH: Sep. 1, 59

450.0

DUE TO: Artery

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Generalized aetherosclerosis — 5 Yrs (?)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sep. 1, 1959, to Sep. 30 1959, that I last saw the deceased alive on 9/30/59, 19__, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shuly M.D.
ADDRESS (Street, city or town, state): Sharpsburg, Md.
DATE SIGNED: 10/3/59

PHYSICIAN'S NAME (Type): Walter H. Shuly M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 5. 1959
22c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY
22d. LOCATION (City, town, or county) (State): NEAR TILGHMANTON WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Rust
ADDRESS: BOONSBORO MD
24a. REC'D BY REGISTRAR DATE: OCT 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur H. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film#250 10-19-59 et

11929

CERTIFICATE OF DEATH

Reg. Dist. No. 11918

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 701 SPRUCE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REV. Middle CHARLES F. Last ROSS

4. DATE OF DEATH: Month OCTOBER Day 1 Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 29 1898

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months 3 Days 2 IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINE OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: TROY LAUNDRY

11. BIRTHPLACE (State or foreign country): DINGWALL-SCOTLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NO RECORD

14. MOTHER'S MAIDEN NAME: NO RECORD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: MRS. MARJORY ROSS Address: 701 SPRUCE ST. HAGERSTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/12/59, 19____, to 10/1/59, 19___, that I last saw the deceased alive on 9/30/59, 19_____, and that death occurred at 12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert V.L. Campbell M.D. ADDRESS (Street, city or town, state): 145 W Washington St DATE SIGNED: 10/2/59

PHYSICIAN'S NAME (Type): Robert V.L. Campbell Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Oct. 4, 1959

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

22d. LOCATION (City, town, or county) (State): HAGERSTOWN WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Bast ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: OCT 8 '59

24b. REGISTRAR'S SIGNATURE: Arline L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. ROBERT V.L. CAMPBELL 145 W. WASH. CO. MD

VS A15 (4) 1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11930

CERTIFICATE OF DEATH

11919 Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission)
a STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#2

c. LENGTH OF STAY IN 1b: 25 yrs.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown R#2

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

d STREET ADDRESS: Hagerstown R#2

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	DAVID	PIERCE	SEYLAR		Oct.	16,	1959

5. SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
Male	White		Feb.7,1896	63 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Construction	Mercersburg,Penna.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David Pierce Seylar	Ida Kershner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
No	235-12-1467	Mrs.Lula S.Seylar R#2 Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrascoma — INTERVAL BETWEEN ONSET AND DEATH: 18 mos
200.2
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Benign prostate hypertrophy — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Aug 1, 1958 to Oct 16, 1959, that I last saw the deceased alive on Oct 15, 1959, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto M.D. — ADDRESS (Street, city or town, state): 217 W. Washington Street — DATE SIGNED: 10/19/59

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county)	(State)
Burial	10/19/59	Rest Haven Cemetery	Hagerstown	Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown,Md.	OCT 20 '59	Catherine S. Kiana

Wm. G. Host.

TO HOSPITAL OR [illegible]: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11931 — Reg. Dist. No. 11920

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2225 Virginia Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 2225 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT — Middle HARTLE — Last SHADRACH

4. DATE OF DEATH: Month October — Day 27 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 18, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator

10b. KIND OF BUSINESS OR INDUSTRY: Paper Hanging

11. BIRTHPLACE (State or foreign country): Lyons, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Shadrach

14. MOTHER'S MAIDEN NAME: Annie Hartle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 219-20-3314

INFORMANT: Mrs. R. H. Shadrach — Address: 2225 Virginia Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac collapse — INTERVAL BETWEEN ONSET AND DEATH: Min
DUE TO (b): Myocardial failure — Min
DUE TO (c): Arteriosclerotic heart — Yrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema and Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Oct 27, 1959, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis S Craft M.D. — ADDRESS (Street, city or town, state): 116 E Antietam St Hagerstown Md — DATE SIGNED: 10/27/59

PHYSICIAN'S NAME (Type): Louis S Craft

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/30/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

Wm. C. Hoak

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11932

CERTIFICATE OF DEATH

11921 Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) — a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 149 N. Potomac St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Upton — Last: Shank
4. DATE OF DEATH: Month: 10 — Day: 6 — Year: 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-14-1903
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Md. Ribbon Co.,
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob H. Shank
14. MOTHER'S MAIDEN NAME: Clara Shives

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-7660
INFORMANT: D. Howard Shank — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO (b): hypertensive cardiovascular disease — 17½ years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): aortic insufficiency due to Lues; and late latent central nervous system Lues.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 15, 1959, to Oct. 6, 1959 that I last saw the deceased alive on Oct. 6, 1959, and that death occurred at 8:30 DST A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm T. Layman M.D.
ADDRESS (Street, city or town, state): 100 Professional Arts Bldg.
DATE SIGNED: 10/7/59
PHYSICIAN'S NAME (Type): William T. Layman, M.D. Hagerstown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10-9-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: OCT 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11922

11933

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BIG POOLE
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First UPTON — Middle CLAY — Last SHIVES

4. DATE OF DEATH: Month OCTOBER — Day 18 — Year 19 59

5 SEX: MALE
6. COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEBRUARY 16, 1877
9 AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months 6 — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TRACK FOREMAN RAILROAD
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): BIGPOOLE, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL SHIVES
14 MOTHER'S MAIDEN NAME: ELIZEBETH WEAVER

15 WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-09-6009
INFORMANT: MISS LEANA SHIVES — Address: BIG POOLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO (b) Strangulated Inguinal Hernia — 6 days
DUE TO (c) following Operation 10/12/59

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophy of Prostate a Infection
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 1959 to Oct 18, 1959 that I last saw the deceased alive on Oct 17, 1959, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D.
ADDRESS (Street, city or town, state): Clear Spring Md.
DATE SIGNED: 10/19/59
PHYSICIAN'S NAME (Type): David R Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 21, 1959
22c. NAME OF CEMETERY OR CREMATORY: SHANKTOWN CEMETERY
22d. LOCATION (City, town, or county) (State): SHANKTOWN, MD.

23 FUNERAL DIRECTOR'S SIGNATURE: John F. Wade
ADDRESS: CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE: OCT 22 '59
24b. REGISTRAR'S SIGNATURE: Cortland S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11934

11923

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 48 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 202 N. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle SHRADER Last

4. DATE OF DEATH: Month October Day 16 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1887
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): Greencastle, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob P. Shrader
14. MOTHER'S MAIDEN NAME: Ellen Lanhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-09-7934A
17. INFORMANT: Jack E. Shrader Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Gen. Arterio sclerosis Coronary Disease
DUE TO
(c) Fracture (Rt) Femur — 7 Wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell while walking in home
20c. TIME OF INJURY: Hour ___ a. m. p. m. Month, Day, Year: Aug 28 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Hagerstown (County) Washington (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: H. E. Suter Jr. M.D.
EXAMINER'S NAME (Type): H. E. Suter Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Hagerstown Md
DATE SIGNED: 10/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/19/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): ~~Maryland~~ Greencastle, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11924

CERTIFICATE OF DEATH

11935

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 42 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL HAGERSTOWN
d. STREET ADDRESS: RT.#4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ANNA — Middle MAE — Last SHUBERT

4. DATE OF DEATH: Month OCTOBER — Day 6 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/24/1894

9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL HARDEN

14. MOTHER'S MAIDEN NAME: SARAH MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-24-9697

INFORMANT: MR. WILLIAM SHUBERT — Address: RT.#4 HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 201K
DUE TO (b): Cardiac Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (c): Hypertension, Vascular Lesion — 5 years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-1-59 19____, to 10-6-59, 1959, that I last saw the deceased alive on 10-6-59, and that death occurred at 7:30 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: A. W. Dewitt M.D. — ADDRESS (Street, city or town, state): Hagerstown Md. — DATE SIGNED: 10/9/59

PHYSICIAN'S NAME (Type): DEWITT

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/9/59

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Normont, Hagerstown, Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11936

CERTIFICATE OF DEATH

11925
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Wash. Co. Hospital

2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d STREET ADDRESS: 432 N. Colonial Drive
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Charles Middle Melvin Last Slick

4. DATE OF DEATH: Month 10 Day 31 Year 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-6-1875
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b KIND OF BUSINESS OR INDUSTRY: auto mechanic
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Slick
14. MOTHER'S MAIDEN NAME: Catherine Rettburg

15 WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: 214-09-9387
INFORMANT: Charles E. Slick Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac failure is Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

602X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): left hydronephrosis — 1 mo.

DUE TO (c): Left ureteral calculus. — ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p m Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I attended the deceased from _____ 19____ to Oct 31, 1959, that I last saw the deceased alive on Oct 31, 1959, and that death occurred at 9:55 A M, from the causes and an the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Joseph C Krupp M.D. M.D

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 11-3-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a REC'D BY REGISTRAR DATE: NOV 4 '59
24b. REGISTRAR'S SIGNATURE: Clifton S Kraiss

TO HOSPITAL ON ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11937

11926

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 No

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 704 Midway Rd. Hagerstown, Md.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Charles Middle Nathan Last Smoke.

4. DATE OF DEATH: Month 10 Day 20 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 28, 1893
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Checker
10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft
11. BIRTHPLACE (State or foreign country): Orrstown, Franklin Co.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Smoke
14. MOTHER'S MAIDEN NAME: Sadie Mae Shirley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 188-09-9394
17. INFORMANT: Mrs. Emma May Smoke — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Small bowel — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1959, to 20 Oct, 1959, that I last saw the deceased alive on 19 Oct, 1959, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Eldon D Hoachlander M.D. — ADDRESS (Street, city or town, state): 115 W Wash St — DATE SIGNED: 10/20/59

PHYSICIAN'S NAME (Type): Eldon D Hoachlander — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/22/1959
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland Co. Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Harold M. Zimmerman — ADDRESS: Hagerstown Md.

24c. REC'D BY REGISTRAR DATE: OCT 22 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11935 : **CERTIFICATE OF DEATH** Reg. Dist. No. 11927 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d. STREET ADDRESS: R.F.D. #3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First OSCAR Middle MILTON Last STOTTLEMYER

4. DATE OF DEATH: Month October Day 5 Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 10, 1897

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Head Custodial

10b. KIND OF BUSINESS OR INDUSTRY: Reformatory

11. BIRTHPLACE (State or foreign country): near Braddock Heights, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ulysses S. Stottlemyer

14. MOTHER'S MAIDEN NAME: Mary E. Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-9183

17. INFORMANT: Mrs. Emma Stottlemyer Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary artery sclerosis — ?

DUE TO

(c) Arteriosclerotic heart disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 Sept, 1959, to 5 Oct, 1959, that I last saw the deceased alive on 4 Oct, 1959, and that death occurred at 5:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Avenue Hagerstown, Maryland — DATE SIGNED: 5 October 1959

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/7/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE OCT 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur A. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11952

CERTIFICATE OF DEATH

11929
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SOUTH MAIN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: SOUTH MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: AMANDA — Middle: MYRTLE — Last: STOVER

4. DATE OF DEATH: Month: OCTOBER — Day: 12 — Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 20. 1889

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: 1 Days: 22 — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): DAHLGRENS FRED. CO MD. USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LUTHER M. WARRENFELTZ

14. MOTHER'S MAIDEN NAME: ANNIE SMITH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 218-24-2183

INFORMANT: L. DEWEY WARRENFELTZ — Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS ALTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 12, 1959, to Oct 12, 1959, that I last saw the deceased alive on Oct. 12, 1959, and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D — ADDRESS (Street, city or town, state): Boonsboro, Md. — DATE SIGNED: 10/13/59

PHYSICIAN'S NAME (Type): G. W. LeVan

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT. 15. 1959

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John D. Bast — ADDRESS: BOONSBORO MD.

24a. RECEIVED BY REGISTRAR DATE: OCT 15 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11936

1193[illegible]EDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. #3

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown
d. STREET ADDRESS: R.F.D. # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LOTTIE — Middle: LEE — Last: STULL
4. DATE OF DEATH: Month: October — Day: 23 — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 31, 1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): near Sharpsburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Crampton
14. MOTHER'S MAIDEN NAME: Frances Saylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-32-7278A
17. INFORMANT: Mrs. Albert Sypolt — Address: Hagerstown, Md. Rt. 3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	1½ hrs
DUE TO (b)	Arteriosclerotic Heart Disease	6 yrs
DUE TO (c)	Fracture Femur	6 mos

420.0 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in home
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 4-22-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Hagerstown (County): Wash. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ / Inspection ☒ Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: J. E. Wetto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/24/59
EXAMINER'S NAME (Type): JOE E. WETTO JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/26/1959
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d LOCATION (City, town, or county): Hagerstown, (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Maryland
24a. REC'D BY REGISTRAR: DATE OCT 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11939

11931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 131 Aisquith St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elsie — Middle: Terry — Last:

4. DATE OF DEATH: Month: Oct. — Day: 26 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-2-1915

9. AGE (In years last birthday): 43 yrs
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Quickley

14. MOTHER'S MAIDEN NAME: Carrie Braxton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Carrie Quickley — Address: 130 N. Aisquith St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): uremia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO
445X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Nephrosclerosis — unknown
DUE TO
(c) Hypertension, malignant — 3 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Paget's disease of the skull 2) Hypertensive encephalopathy 3) Cerebrovascular accident, multiple

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year: Hour: a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 28, 1959 to Oct. 26, 1959, that I last saw the deceased alive on October 26, 1959, and that death occurred at 6:39 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): western md. state Hospital — DATE SIGNED: Oct. 26, 1959

PHYSICIAN'S NAME (Type): Victor L. Ramos — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-31-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery

22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Randolph J. Collick — ADDRESS: 1412 E. Preston

24a. REC'D BY REGISTRAR — DATE: OCT 30 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

Item 18 Film 251 11-2-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11940

11932 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 3 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b COUNTY Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sharpsburg
d. STREET ADDRESS Sharpsburg
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lydia Middle Ann Last Tucker
4. DATE OF DEATH Month 10 Day 25 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan. 10 1876.
9. AGE (In years last birthday) 83 yrs.
IF UNDER 1 YEAR Months 9 Days 13 IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11 BIRTHPLACE (State or foreign country) Near Winchester . . Va.
12 CITIZEN OF WHAT COUNTRY? U.S.A

13 FATHER'S NAME David Ebersole
14. MOTHER'S MAIDEN NAME Emma Unger

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16 SOCIAL SECURITY NO None
INFORMANT Address Mr. Howard S. Myers Clearspring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a) Thrombosis of pulmonary artery — INTERVAL BETWEEN ONSET AND DEATH: appx 2 Weeks
DUE TO
(b) Coronary artery disease, Severe — 5 years
DUE TO
(c) Hyperten ive cardiovascular disease — 5 years
Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐
Diabetes mellitus

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 23, 1959 to Oct. 25, 1959, that I last saw the deceased alive on Oct 25, 1959, and that death occurred at 12:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Young E. Chun M.D. ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave. Hagerstown Md DATE SIGNED Oct 25. 59
PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 28-59
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery
22d LOCATION (City, town, or county) (State) Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE Albert R Zeiler ADDRESS Williamsport, Md
24a. REC'D BY REGISTRAR DATE OCT 28 '59
24b. REGISTRAR'S SIGNATURE Clifton S Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11954

11933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: 3 Mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 621 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAISY — Middle ELLEN — Last TURNER-GROVE

4. DATE OF DEATH: Month Oct — Day 7 — Year 1959

5. SEX: Famale

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr 16 1881

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md Breathedsville Wash Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Scott Palmer

14. MOTHER'S MAIDEN NAME: Sarah E. Hennesy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: John C. Palmer 20 Delwood Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 15, 19 59, to Oct 7, 19 59, that I last saw the deceased alive on October 6, 19 59, and that death occurred at 12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Wilson M.D.
ADDRESS (Street, city or town, state): Boonsboro, Md
DATE SIGNED: 10/10/59

PHYSICIAN'S NAME (Type): A. Wilson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/10/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: OCT 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11941

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 336 N. Jonathan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Matthews Middle Pulpus Last Tyler
4. DATE OF DEATH Month Oct. Day 5 Year 1959
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 27 1919
9. AGE (In years last birthday) 39 yrs.
IF UNDER 1 YEAR: Months 10 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY City Hagerstown
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME James Earl Tyler
14. MOTHER'S MAIDEN NAME Catherine Pulpus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 2
16. SOCIAL SECURITY NO. 218 03 4042
17. INFORMANT Mrs. Marion Turner Williamsport Md. Address Conococheague St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic Otitis Media, left	2 months
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Lateral Sinus Thrombosis, left	1 week
DUE TO (c)	Pyogenic Leptomeningitis	1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Struck on head with baseball bat

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In fight
20c. TIME OF INJURY Hour 2 a. m. p. m. Month, Day, Year 9-12 59
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hagerstown (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.
DATE SIGNED 10/6/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 8 1959
22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery
22d. LOCATION (City, town, or county) Williamsport (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Edith Virgil ADDRESS Williamsport Md
24a. REC'D BY REGISTRAR DATE OCT 8 '59
24b. REGISTRAR'S SIGNATURE Catherine K. Hamm

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11935

CERTIFICATE OF DEATH

11955 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wash. MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Wash
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithburg - Rural
c. LENGTH OF STAY IN 1b Life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Smithburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD2 - Smithburg, Md.
d. STREET ADDRESS RD2 - Smithburg
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First LEWIS Middle MARTIN Last WEBER
4. DATE OF DEATH Month Oct Day 24 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 2/6/1932
9. AGE (In years last birthday) 27 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Wash. Co., Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edgar Weber
14. MOTHER'S MAIDEN NAME Ada H. Martin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 215-36-7947
17. INFORMANT Mrs. Mary Weber Address RD2 Smithburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma multiforme tumor — 7 mo.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-25-59, 19__, to 10-24-59, 19__, that I last saw the deceased alive on 10-27-59, 19__, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Charles F. Hess M.D. ADDRESS (Street, city or town, state) Smithburg, Md. DATE SIGNED 10-27-59

PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) B
22b. DATE THEREOF 10/27/59
22c. NAME OF CEMETERY OR CREMATORY Stouffer's Cem.
22d. LOCATION (City, town, or county) (State) Smithburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnich ADDRESS Greencastle, Pa.
24a. REC'D BY REGISTRAR DATE OCT 28 '59
24b. REGISTRAR'S SIGNATURE Charles S. Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11942 **CERTIFICATE OF DEATH** Reg. Dist. No. 11936

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 2302 VIRGINIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MORLEY Middle HAMILTON Last WELBANKS
4. DATE OF DEATH: Month OCTOBER Day 15 Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/20/1897
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN
10b. KIND OF BUSINESS OR INDUSTRY: BOOK PUBLISHING
11. BIRTHPLACE (State or foreign country): CO. CANADA
12. CITIZEN OF WHAT COUNTRY? CANADA

13. FATHER'S NAME: STANLEY WELBANKS
14. MOTHER'S MAIDEN NAME: HARRIETT HAMILTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 212-38-7862
INFORMANT: MRS. MARTHA VANALLEN Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration of Vomitus
DUE TO (b): Gastric Hemorrhage
DUE TO (c): Diffuse Gastritis
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last: 543X
INTERVAL BETWEEN ONSET AND DEATH: 2-5 mins intermittent for 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Wound Abscess
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1959 to Oct 15 1959, that I last saw the deceased alive on Oct 15 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Max E Bykat M.D. ADDRESS (Street, city or town, state): 28 W Potomac DATE SIGNED: 10-16-59
PHYSICIAN'S NAME (Type): Williamsport Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/18/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. T. Wormert Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: OCT 19 59
24b. REGISTRAR'S SIGNATURE: Arthur L. Mowen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11956 **CERTIFICATE OF DEATH** 11937

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 205 S. Artizan St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Williamsport
d. STREET ADDRESS: 205 S. Artizan
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Buelah — Middle: E. — Last: Wiley

4. DATE OF DEATH: Month: October — Day: 16 — Year: 1959

5 SEX: Female — 6 COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 7, 1894 — 9 AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months: 4 — Days: 11 — IF UNDER 24 HRS: Hours: — Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winton Moudy
14. MOTHER'S MAIDEN NAME: Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Mr. William Wiley — Address: Williamsport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/15/59, 19, to 10/16/59, 19, that I last saw the deceased alive on 10/16/59, 19, and that death occurred at 6:27 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Young, M.D. — ADDRESS (Street, city or town, state): Williamsport, Md. — DATE SIGNED: 10/16/59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 19, 1959
22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leaf — ADDRESS: Williamsport, Md.
24a. REC'D BY REGISTRAR DATE: OCT
24b. REGISTRAR'S SIGNATURE: 20 '59 Arthur S. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11938

Reg. Dist. No. 11957

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEAVER CREEK Rural
c. LENGTH OF STAY IN 1b: 4½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAGERSTOWN MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEAVER CREEK RURAL
d. STREET ADDRESS: HAGERSTOWN MD. R.1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ANNA Middle ELIZABETH Last WILSON

4. DATE OF DEATH: Month OCTOBER Day 27 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MARCH 28 1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months 6 Days 29 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): POLO ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT M. WILSON

14. MOTHER'S MAIDEN NAME: CLARA BOWMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

INFORMANT: MERLE MARTZ Address: HAGERSTOWN MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial insufficiency	4 hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	Hemiplegia Rt	10 yrs
DUE TO		
(c)	Cerebral Sclerosis	15 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour o m. p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Sept 25, 1957, to Oct 27, 1959, that I last saw the deceased alive on Oct 27, 1959, and that death occurred at 4.4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. A. Kohler M.D. ADDRESS (Street, city or town, state): Smithsburg Md DATE SIGNED: 10/27/59

PHYSICIAN'S NAME (Type): G. A. KOHLER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: OCT. 29. 1959

22c. NAME OF CEMETERY OR CREMATORY: SMITHSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): SMITHSBORO WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bart ADDRESS: BOONSBORO MD.

24a. REC'D BY REGISTRAR DATE: NOV 3 '59

24b REGISTRAR'S SIGNATURE: Clifton S Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11939

11958

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#2

c. LENGTH OF STAY IN 1b: 2 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing Home

d. STREET ADDRESS: R#2 Hagerstown

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	JAMES	PATRICK	WILSON		October	24	1959

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	NEVER MARRIED ☒	April 8, 1883	76 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Washington Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Richard Wilson	Mary Catherine Haggerty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
No	230-09-4846	Harvey Franklin Wilson	8 Braxton Alley Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED IMMEDIATE CAUSE (a): Arteriosclerotic Heart Dis. — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from June 1957, 19__, to Oct 24, 1959 that I last saw the deceased alive on Oct 24, 1959 and that death occurred at 2:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Clear Spring, Md. DATE SIGNED: 10/24/59

PHYSICIAN'S NAME (Type): David K. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/28/59	Rest Haven Cemterey	Hagerstown Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown, Md.	OCT 28 '59	Arthur S. Travis

Wm. A. Hook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11943 — Reg. Dist. No. 11941

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 W 31 9
d. STREET ADDRESS: 834 Stamford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELOISE — Middle — Last Zeihm

4. DATE OF DEATH: Month Oct — Day 26 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4, 1893

9. AGE (In years last birthday): 66 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Campbell Smith

14. MOTHER'S MAIDEN NAME: Mary Catherine Somers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-32-9472

INFORMANT: Mrs. Gordon Priest — Address: 935 Greenbriar Rd. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Spontaneous entero-enterostomy with multiple abscesses — INTERVAL BETWEEN ONSET AND DEATH: 24 days

DUE TO (b): metastatic carcinoma of pelvic organs — 7 mos

DUE TO (c): carcinoma of rectum — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 1, 1959, to Oct. 26, 1959, that I last saw the deceased alive on October 26, 1959, and that death occurred at 4:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): Western Md. State Hospital — DATE SIGNED: Oct. 26, 1959

PHYSICIAN'S NAME (Type): VICTOR L. RAMOS — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-29-1959

22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park

22d. LOCATION (City, town, or county) (State): Woodlawn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: 320 E. WASHINGTON AVE

24a. REC'D BY REGISTRAR DATE: OCT 29 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11942

11959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wash County — Hancock Rest Home — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md
c. LENGTH OF STAY IN 1b: 1Yr 10 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Rest Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Bedford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bedford (Rural) 75x-3
d. STREET ADDRESS: Route #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

090

3. NAME OF DECEASED (Type or print): First Irvin Middle Adam Last Zembower
4. DATE OF DEATH: Month October Day 23 Year 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 25 1870
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Bedford County Pa
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Zembower
14. MOTHER'S MAIDEN NAME: Emily Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Kenneth Zembower — Address: Son Cumberland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 20yr.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema, Bronchiectasis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-20, 1959, to 10-20, 1959, that I last saw the deceased alive on 10-20, 1959, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank B Thomas III MO M.D. — ADDRESS (Street, city or town, state): Hancock, Md — DATE SIGNED: 10/23/59

PHYSICIAN'S NAME (Type): Frank B. Thomas III, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/26/59
22c. NAME OF CEMETERY OR CREMATORY: P. O. S. of A. Cemetery
22d. LOCATION (City, town, or county) (State): Centerville Penna

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: OCT 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG249 10-9-59 et

11944

11943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. W. Va. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Martinsburg
d. STREET ADDRESS: 1200 W. King Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Zirkle

4. DATE OF DEATH: Month: Oct. — Day: 4 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 17, 1873

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: Revenue

11. BIRTHPLACE (State or foreign country): Barbour Co. W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Zirkle

14. MOTHER'S MAIDEN NAME: Rebecca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: R.H.Zirkle 122 S.Queen St. Martinsburg — Address: W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): Hypertensive Cardio Vascular Renal — 10 years
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-1-59, 19__, to 10-4-59, 1959, that I last saw the deceased alive on 9-30-59, 1959, and that death occurred at 10:40AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E.W. Ditto M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/4/59

PHYSICIAN'S NAME (Type): E.W. Ditto Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/6/59 — 22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery — 22d. LOCATION (City, town, or county): Martinsburg (State): W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. Brown — ADDRESS: Martinsburg W.Va.

24a. REC'D BY REGISTRAR — DATE: OCT 5 '59

24b. REGISTRAR'S SIGNATURE: Carlton A. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55